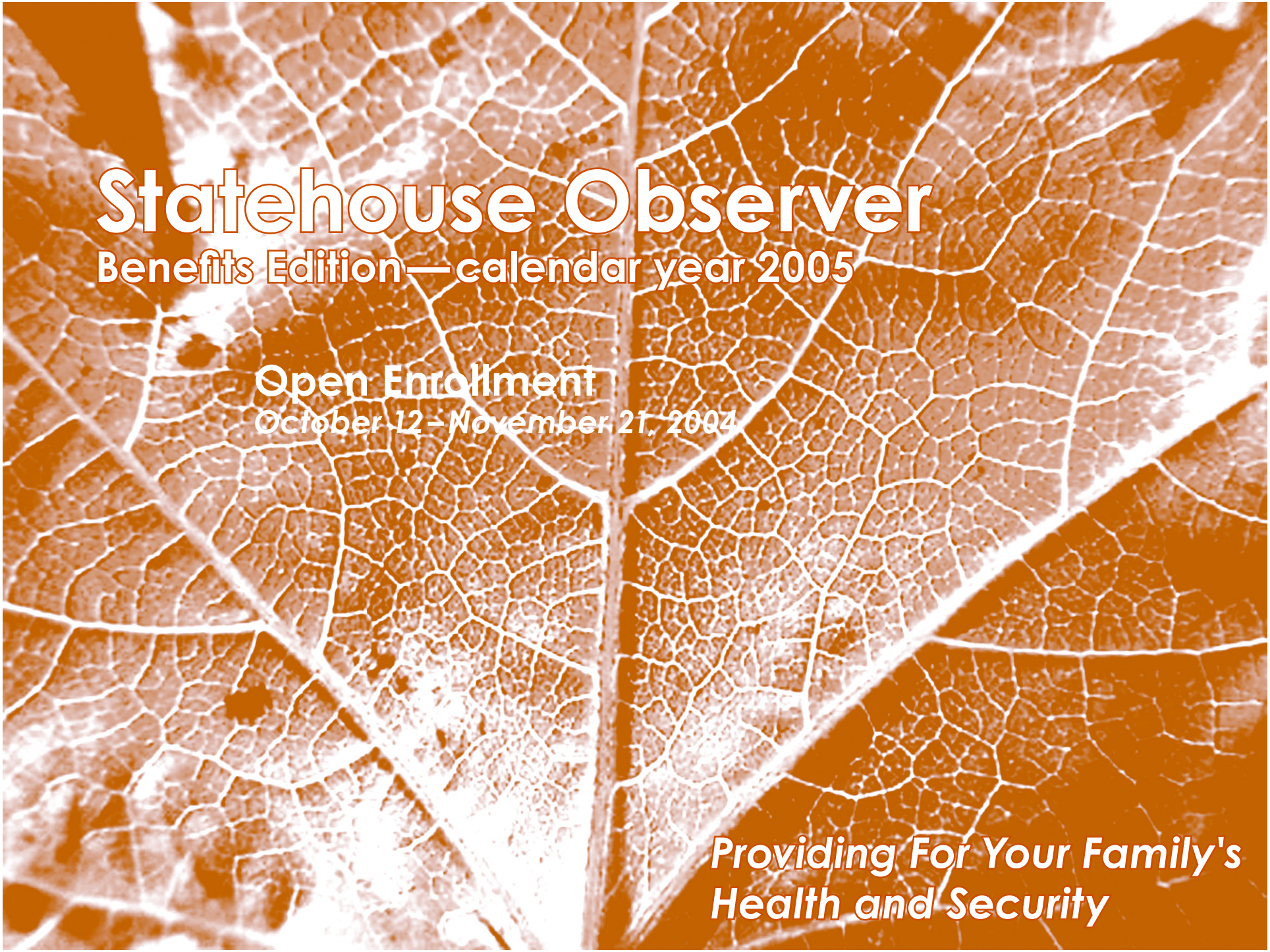

Statehouse Observer
Benefits Edition—calendar year 2005
Open Enrollment
October 12 – November 21, 2004
Providing For Your Family's
Health and Security

STATE OF NEBRASKA

DEPARTMENT OF ADMINISTRATIVE SERVICES
Lori McClurg
Director
Suite 1315, State Capitol
Lincoln, Nebraska 68509-4664
Phone (402) 471-2331

October 1, 2004

Mike Johanns
Governor

Welcome to Open Enrollment 2004. The Open Enrollment period for this year will be from October 12 – November 21, 2004. This is your opportunity to review the many benefit options available to you and select those that best meet your needs.

Take time during the Open Enrollment period to learn about the plans and options being offered. This booklet offers you a quick reference to each plan offered, but is NOT a replacement for insurance company brochures or certificate books. You are strongly encouraged to attend one of the many informational forums during October and November to visit with insurance representatives about their plans. If your schedule will not permit you to attend a meeting, the toll-free phone numbers for each insurance carrier and Internet sites are also accessible to help answer your questions. Additional information and links to insurance company sites can also be found by visiting the DAS – State Personnel web site at http://www.das.state.ne.us/personnel/benefits/index.html.

This year, the State of Nebraska is implementing our new Employee Self Service (ESS) online benefit enrollment. Using Employee Self Service, you will enroll yourself and your dependents in your benefit choices during Open Enrollment. This will give you immediate access to your records and faster response time due to greater processing efficiency. Employees will be able to access Employee Self Service from any computer (some technical requirements needed) at your desk, home, public library and scheduled labs during Open Enrollment. Please check with your Agency Human Resource Office for enrollment instructions.

You must enroll in all of your benefits, as well as adding your dependent and beneficiary information this year. Your current elections will NOT rollover to the next plan year. *If you do not enroll, you will NOT have benefits effective January 1, 2005.*

The goal of this publication is to educate you on benefit options available to you and to increase your understanding of the value of your benefits. You are encouraged to acquire and read the specific company literature for coverages you intend to purchase. Ultimately, you are responsible for the choices you make and to be informed on how to use your benefits effectively. The benefit decisions you make will have a significant impact on you and your family. Please make your decisions wisely, and ask questions if you are unsure about the options available.

Sincerely,

Lori McClurg, Director
Department of Administrative Services

An Equal Opportunity/Affirmative Action Employer

Printed with soy ink on recycled paper

Monthly rates are shown. Biweekly employee pay half per pay period.

Blue Cross Blue Shield

		Employee Cost	State Cost	Total Premium
NE BlueChoice	*Single*	70.10	263.66	333.76
	2/4 Party	175.22	659.16	834.38
	Family	248.80	936.02	1,184.82
NE BlueSelect	*Single*	68.64	258.24	326.88
	2/4 Party	171.60	645.56	817.16
	Family	243.68	916.72	1,160.40

Ameritas

Dental	*Single*	19.96	0	19.96
	2 Party	39.96	0	39.96
	4 Party	57.62	0	57.62
	Family	62.60	0	62.60

VSP

Vision	*Single*	7.40	0	7.40
	2 Party	11.86	0	11.86
	4 Party	12.10	0	12.10
	Family	19.50	0	19.50

Tricare Supplement

Employee only	12.60	47.40	60.00
Employee + 1 Dependent*	25.00	94.00	119.00
Employee + 2 Dependents*	33.60	126.40	160.00

**Dependent can be a spouse and / or child*

Mutual of Omaha

		Employee Cost	State Cost	Total Premium
PPO Plan	*Single*	66.42	249.82	316.24
	2/4 Party	166.02	624.54	790.56
	Family	235.74	886.86	1,122.60
HMO Plan	*Single*	59.84	225.16	285.00
	2/4 Party	149.62	562.88	712.50
	Family	212.46	799.30	1,011.76
POS Plan	*Single*	61.12	229.94	291.06
	2/4 Party	152.82	574.86	727.68
	Family	216.98	816.30	1,033.28

Nebraska: Burt, Butler, Cass, Colfax, Cuming, Dakota, Dixon, Dodge, Douglas, Fillmore, Johnson, Lancaster, Madison, Otoe, Saline, Sarpy, Saunders, Seward, Stanton, Thurston, Washington, and Wayne.

Iowa: Buena Vista, Carroll, Cherokee, Clay, Crawford, Harrison, Ida, Mills, Monona, O'Brien, Plymouth, Pottawattamie, Sac, Sioux, and Woodbury

Mutual of Omaha plans available only in counties listed

Preferred Provider Network Only Plan	*Single*	68.06	256.02	324.08
	2/4 Party	170.14	640.06	810.20
	Family	241.60	908.90	1,150.00
Mutually Preferred POS Plan	*Single*	69.50	261.46	330.96
	2/4 Party	173.76	653.66	827.42
	Family	246.72	928.20	1,174.92

Mutual of Omaha plans available only in counties **not** listed above.

Contents

INTRODUCTION

This enrollment year begins a new process for all of us. It's the first time you will use the computer to elect your benefits during open enrollment through our new Employee Self Service (ESS) application. This online enrollment method is fast, convenient, and easy to learn.

Once you receive your user ID and password, you will be guided through the ESS Open Enrollment process by a series of instructions located on each page. You will be able to view your current elections, travel back and forth by clicking the previous and next buttons, print a copy of your benefits statement and finalize your benefit elections by simply clicking the "I accept" button.

Since this process is so new, we have provided additional time for this year's Open Enrollment period, which begins Tuesday, October 12 and runs through Sunday, November 21. To further assist each of us through this process, the following help features are at your disposal:

- Your agency HR representative
- IMServices Help Desk (402) 471–4636 or ihelp@notes.state.ne.us
- DAS State Personnel Benefits web site
- NIS Web site
- Internal help screens within the Employee Self Service application
- And last but not least, this Statehouse Observer.

Many of you have already logged into NIS and are familiar with specific processes. However, not everyone is familiar with how to use the Employee Self Service features.

Employee user ID's and passwords have been distributed to agencies and will be available to you prior to Open Enrollment. Your unique user ID and password represent your electronic signature and should be kept confidential. Once your agency provides you with your user ID and password, you may wish to visit the following ESS applications for some practice (all of these menu options are available right now):

- Pay Stub Review (review and print current and historical pay stubs)
- Leave Balance Inquiry (see your current leave balances online)
- Employee Personal Profile (review your profile information online)
- Current Elections (review your 2004 benefit elections prior to Open Enrollment).

One of the great things about ESS Open Enrollment is that you will be able to access the system in a number of ways. You can log in from home or at the work site, as long as you have access to the Internet. Some agency HR staff have been busy scheduling training sessions and labs for your convenience. Check with your Agency HR representative for further information regarding your specific agency instructions.

Please refer to the "Highlights" located on the right edge throughout this document, as well as the page devoted to "Frequently Asked Questions" (FAQ's). These documents also reside on the DAS State Personne Benefits web site **www.das.state.ne.us/personnel/benefits**. They will be continually updated as more questions arise.

The following page will provide a brief outline of the on-line enrollment process. Detailed instructions are available on the DAS State Personnel Benefits web site.

Things to Remember:

- Allow enough time to thoroughly complete the open enrollment process from beginning to end. Complete the Benefits Open Enrollment Worksheet in this document before logging in and enrolling.
- Only the plans for which you are eligible will appear. The Benefit group you are already assigned to dictates your plan options.
- **You must complete the Open Enrollment process through the "I accept" button and receive a transaction number from the final benefit confirmation statement or your changes will not be saved.**

Need Help?

IMServices Help Desk
402–471–4636 or
ihelp@notes.state.ne.us

DAS State Personnel Benefits web site
www.das.state.ne.us/personnel/benefits

Online Enrollment Process

Step 1–Log on to Employee Self Service

- Go to the **www.nis.ne.gov** sign on web page.
- Click on the "Sign on to NIS" button. If warned about viewing pages over a secure connection, click OK.
- Enter your user ID in the User ID field.
- Enter your password in the Password field.
- Click the Login button.
- If prompted to change your password, enter your new password in the New Password and Repeat password fields, then click Change Password.
- Click the radio button next to JPD7333 (the Production environment), and click the OK button.
- Click on the Roles icon and ESS to make sure you are seeing the correct menus.
- Click on the Employee Self Service folder.
- Click on the Agency folder.
- Click on the Self Service Choices folder.
- Click on the Employee Benefits folder.
- Click on Open Enrollment to begin online enrollment.

Step 2–Enrollment

- Read the instructions.
- Click Next when you are ready to proceed to complete each of the following tasks:
  - Employee Personal Information
  - Employee Phone Numbers
  - Current Elections–PRINT THIS FOR COMPARISON PURPOSES! (use File, and Print from your browser menu bar)
  - Dependent List
  - Health
  - Beneficiary List
  - Life Insurance
  - Flexible Spending Accounts.

Step 3–Preview Benefit Changes

- Elections Pending Submission Statement
- Review and Update Elections
- Click the Submit Your Changes button

Step 4–Accept Benefit Changes

- Clicking the "I accept" button means you cannot make changes without re-entering the Open Enrollment process during the Open Enrollment period (Oct. 12–Nov. 21, 2004);
- You are providing an electronic, legal signature.
- Final Benefit Confirmation Statement–PRINT THIS TO KEEP THE TRANSACTION NUMBER HANDY! (use File, and Print from your browser menu bar)

Step 5–Log out

- Click the blue Logout link in the upper right-hand corner to exit NIS completely.

Benefits Open Enrollment
October 12—November 21, 2004

Important Note—If you decide to make changes later, during the Open Enrollment Period of October 12–November 21, you will need to repeat all of the steps listed. You will receive a new Final Benefits Confirmation Statement with a new Transaction Number. The last Final Benefit Confirmation that is in the system when Open Enrollment closes on November 21 at midnight, will be processed for your 2005 elections.

Web site Information

www.nis.ne.gov
NIS sign-on page

www.das.state. ne. us/nis
NIS Home page

www.das.state. ne. us/personnel/benefits
DAS State Personnel Benefits web site

IMServices Help Desk

402–471–INFO (4636)
or
ihelp@notes.state.ne.us

How do Flexible Spending Accounts (FSAs) work?

You decide how much to set aside in each account for the year, up to the maximums in each plan. This is called your "election." Your election will be divided by the number of paychecks you expect to receive next year. Your compensation will be reduced by this amount each paycheck to fund the accounts.

After you have incurred a qualifying expense, you will file a claim with ASI. ASI will reimburse you for the claimed amount. ASI processes claims daily, no later than the 1st business day after they receive your claim. An expense is considered incurred when the services are provided or the products are ordered. This may or may not be the same time that you are billed or pay for the services or products. Expenses must be incurred during the current Plan Year, January 1 through December 31, 2005.

You should include only those expenses that you are sure you will incur when figuring your election, since any amount you do not incur for qualifying expenses cannot be returned to you. You can use the worksheet on the next page to help you plan your elections.

What are the annual maximums and minimums?

- The Medical FSA maximum is $3,000, minimum per calendar year $12.
- The Dependent Care maximum is $5,000 per family for single and married employees ($2,500 if married and filing separate tax returns). However, you may not elect an amount that is more than your spouse's earned income (if married) or more than half your earned income. Minimum is $72 per calendar year.

Can I claim these expenses on my tax return?

You cannot claim the items reimbursed to you through the FSA on your Federal tax return. Medical expenses paid through the FSA are 100% tax exempt. On your tax return, medical expenses are only deductible to the extent they exceed 7.5% of your adjusted gross income.

Which is better: the Flex Spending Plan or the Child Care Credit?

Generally, those families with an adjusted gross income of $31,000 or more or who spend more than $3,000 on care for only one child in day care will save more with the flexible spending plan. However, you should check with your tax advisor concerning your circumstances. You cannot use the credit for any amounts reimbursed through the plan.

Can I change my elections?

Generally, no. However, there are a few situations that will allow you to make a change. These situations are very limited. Please contact the DAS State Personnel Benefits Office for information concerning making changes. You should plan on not being able to make a change during the year. Your election will terminate at the end of each plan year. To continue participation you will need to make a new election each year during open enrollment.

How and when do I enroll?

Current employees can only enroll during open enrollment. However, if you are a newly hired state employee, you can enroll at any time within 30 days of your hire date. Certain status changes might allow you to enroll later. Contact your Agency HR Representative for enrollment assistance.

Qualifying Health Care Expenses

Qualifying health care expenses are medical expenses, as defined in section 213 of the Internal Revenue Code, that cannot be paid by any insurance, except insurance premiums and long-term care expenses (refer to IRS Publication 502). Included are such things as:

- Eye exams, contact lenses, contact lens solution, glasses, LASIK surgery
- Dental exams, cleaning, fillings, crowns, braces
- Prescription drugs, medicines and insulin
- OTC medicines & drugs treating an existing medical condition (view ASI web site for details at www.asiflex.com)
- Hearing aids and exams
- Routine doctor visits, including chiropractic care.

You can include expenses for everyone on your tax return, even if you do not cover them on your medical insurance.

Ineligible Expenses

- Insurance premiums, warranties, service agreements
- Cosmetic procedures or products
- Health club dues for general good health
- General good health or hygiene items that are available over-the-counter

Save $25 or more for every $100 you put in the Flexible Spending Accounts!

Assume you have a family income of $24,000 and will have at least $1,500 in qualifying expenses next year.

Without a Flex Plan		With a Flex Plan
$24,000	Annual Compensation	$24,000
0	Tax free expenses	−1,500
$24,000	Taxable income	$22,500
−1,836	FICA@ 7.65%	−1,721
−2,850	Federal Income Tax @15% (after $5000 exemptions)	−2,625
−570	State Income tax @ 3%	−525
$18,744	Net pay check	$17,629
−1,500	After tax expenses	0
$17,244	Actual take home pay	$17,629
	Net cash savings	**$385**

This is just an example. The savings will vary for each participant. Calculate your own potential savings using your marginal tax bracket. Consult your tax advisor if you have any questions.

Qualifying Dependent Care Expenses

Qualifying dependent care expenses are child and/or adult dependent care expenses you incur that enable you to work. If you are married, your spouse must also work or be a full-time student. You must claim the dependent on your tax return. If you are divorced, you must be the custodial parent greater than 50%, but are not required to claim the tax exemption. Your child must be under 13, or if care is for an older person he/she must be incapable of self-care (refer to IRS publication 503). Expenses include such things as:

- Day care centers (must comply with state and local laws) or baby-sitters
- Pre-school (before Kindergarten)
- General-purpose day camps.

Ineligible Expenses

- Food, transportation, or activity fees
- Education expenses (Kindergarten or higher)
- Overnight camps (including day time portion)

Care provider cannot be:

- Your spouse or any dependent
- Your child under the age of 19
- Private school (Kindergarten or higher)

Worksheet

Health Care Expenses

Estimated medical, dental, vision expenses between January 1 and December 31, 2005

Orthodontics and dental _____
Glasses, contacts, solutions _____
Deductibles _____
Co-pays _____
Medicines, drugs & insulin _____
Other medical _____

Total health care expenses: ☐

Dependent Care Expenses

Day care center _____
Baby-sitters _____
Day camp _____
Pre-school _____
Before/after school care _____

Total Dependent Care Expenses: ☐

Be sure to consider summer vacations when you make your estimate!

If you have questions concerning eligible expenses or claims filing procedures on your FSA Accounts, please contact DAS State Personnel Benefits at **402−471−4107** or:

ASI
P O Box 6044
Columbia, MO 65205−6044
1−800−659−3035
www.asiflex.com
asi@asiflex.com

The State of Nebraska will continue to offer employees and their dependents optional vision care benefits through Vision Service Plan (VSP). VSP has the most extensive nationwide network of doctors who provide quality eye care and materials at very competitive prices. VSP is designed to provide you regular eye examinations and benefits toward vision care expenses including glasses or contact lenses. VSP provides coverage in full after co-pays for materials, except for cosmetic options and a frame exceeding the plan allowance.

Your overall net cost for VSP will be lower due to the lowering of taxed dollars. Once you sign up for the program, you are locked in for 12 months—unless you have a qualifying event under Section 125. Thereafter, you may change your election during the State's annual open enrollment. Under VSP, you enjoy savings off retail costs with the monthly deductions.

Since VSP is designed to cover your visual needs rather than cosmetic materials, you will be responsible for blended, progressive, oversize, UV protection, coated or laminated lenses and additional cosmetic lenses, as well as optional cosmetic processes, certain limitations on low vision, and a frame that exceeds the plan allowance. All of these options are available through VSP doctors at substantially reduced charges. The doctor will itemize all non-covered charges and have you sign a form for documentation.

Your Contribution

	monthly rate
Employee Only	$7.40
Employee Plus Spouse	$11.86
Employee Plus Children	$12.10
Employee Plus Family	$19.50

Your Co-pays with VSP Network Doctor

Exam	$10
Lenses	$10
Frames (up to $115)	$10
Contacts (up to $105)	no co-pay applies

Out-of-Network Reimbursement Amounts:

Exam	up to $35
Lenses	
single vision	*up to $25*
lined bifocal	*up to $40*
lined trifocal	*up to $55*
lenticular	*up to $80*
Frames	up to $35
Contacts	up to $105

Your Coverage

Exam, covered in full — every 12 months

Prescription Glasses

Lenses, covered in full — every 24 months
single vision, lined bifocal, and lined trifocal lenses

Frames — every 24 months
frame of your choice covered up to $115. Plus, 20% of any out-of pocket costs.

–OR–

Contacts — every 24 months

When you choose contact lenses instead of glasses, your $105 allowance applies to the cost of your contacts and the fitting and evaluation exam. This evaluation is in addition to your vision exam to ensure proper fit of contacts. If disposable contact lenses are purchased, VSP will cover up to $105 for a one-year supply. Annual supplies of popular contact lenses are available to you at competitive prices. Visit www.vsp.com for more details on contact lens value programs.

Extra Discounts and Savings

Laser Vision Correction Discounts

Prescription Glasses

- Polycarbonate lenses for dependent children covered in full
- Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives
- 20% off additional prescription glasses and sunglasses*

Contacts

- Exclusive pricing on annual supplies of popular brands
- 15% off cost of contact lens exam (fitting and evaluation)
- Available from the same VSP doctor who provided your eye exam within the last 12 months.

* VSP offers even more value by providing a 20% discount on non-covered pairs of prescription glasses or a 15% discount off the participating doctor's professional services when you purchase prescription contact lenses. These discounts are only available through the VSP participating doctor who originally performed your eye

If you have questions regarding your vision coverage or need to locate a VSP doctor, visit VSP's web site at **www.vsp.com** or call VSP at **1–800–877–7195**. When scheduling your eye appointment, identify yourself as a VSP member covered through the State of Nebraska and provide the doctor with your social security number. The doctor will contact VSP to verify your eligibility and obtain the authorization for services and materials. You are responsible for co-payments and cosmetic options purchased.

Dental Insurance—A Low Cost Benefit

You can assure yourself of getting all or a majority of your premium back in the form of benefits if all you use are the preventive procedures.

For example: If you were to go to the dentist twice a year for typical check-ups, including two adult exams, two cleanings and two sets of bite wing x-rays, Ameritas would reimburse up to $212.00 per year if you use a PPO dentist or $106 if you use a non-PPO dentist (based on Lincoln costs).

If you enroll in the plan with employee only coverage, your annual net cost will be about $167.14 ($13.97 x 12 months) after taking tax savings into consideration. By using the plan to pay for your check-ups, you will receive all or a majority of your premium back in benefits.

Thus, there is no reason for poor dental health. With all the advances in dental care, regular checkups and proper dental maintenance, no one should suffer from tooth decay or dental disease. By participating in the dental program, you have the opportunity to make regular checkups much easier and less costly.

This plan now includes an enhanced benefit called **Dental Rewards**. If you file at least one dental claim during the calendar year and your benefits paid are less than $500 for the year, you will qualify for a reward of a $250 increase in your annual maximum the following calendar year. This continues until you reach a total reward of $1000. The Dental Reward amount earned is reduced by any amount used in any year. Note: Orthodontia and TMJ procedures are excluded from Dental rewards as they have their own maximum benefit.

Ameritas Dental Plan Highlights — **Effective January 1, 2005**

Coinsurance (Plan Pays)	PPO Dentist	Non-PPO Dentist
Type 1(A) Preventive Procedures *exams, cleanings, x-rays, sealants*	100%	50%
Type 1(B) Basic Procedures *fillings, root canals, gum disease, extractions*	80%	50%
Type II Major Procedures *initial and replacement crowns, dentures, bridges*	50%	25%
Orthodontia & TMJ Procedures *(Orthodontia for children to age 19)*	50%	25%
Deductible Amounts		
Type 1(A) Preventive Procedures *Deductible Waived for Preventive Procedures*	$0	$0
Type 1(B) Basic and Type II Major Procedures *Calendar Year—Per Person / Maximum Per Family*	$50 / $150	$50 / $150
Orthodontia & TMJ Procedures	$0	$0
Maximum		
Type I (A)(B) and Type II Procedures *Calendar Year—Per Person*	$1000	$1000
Orthodontia & TMJ Procedures *Lifetime—Per Person*	$2000	$2000

Monthly Cost	Full Cost	Estimated Cost After Tax Savings*
Employee Only	$19.96	$13.97
Employee & Spouse	$39.96	$27.97
Employee & Child(ren)	$57.62	$40.33
Employee, Spouse & Child(ren)	$62.60	$43.82

* *Based on a 30% tax savings including Federal, State, and FICA taxes*

Ameritas is pleased to provide the dental plan with no change in benefits and no change in rates from 2004. In addition, the annual dental maximum benefit has been enhanced with a feature called ***Dental Rewards!*** *(see article)*

Enrollment / Late Entrant

If you and / or your dependent(s) did not enroll within 31 days from being eligible for insurance or elect to become insured again after dropping out of the dental plan, you and / or your dependents will be late entrants. As late entrants, you and / or your dependent(s) benefits will be limited to all Preventive Procedures only for the first 12 months that you are insured. After 12 months, you will have access to all of the plan's benefits.

This form is a benefit highlight, not a certificate of insurance. The coverage outlined here highlights the dental benefits available through Ameritas Life Insurance Corp. You will receive a certificate which will provide a more complete description of the plan after you enroll.

Questions? Please call:

Ameritas Group Claims
Department
1–800–487–5553
Monday–Thursday
7:00 AM to 12:00 AM CST
Friday 7:00 AM to 6:30 PM CST

PPO Information:
Lists are available or use our web site to access PPO listings at **www.ameritasgroup.com**

Note: *The toll free number shown above should be used for local and long distance calls.*

Nebraska Blue*Choice*

This year's Open Enrollment offers State employees new health care plan choices. **Nebraska Blue*Choice*** and **Nebraska Blue*Select*** are new plans Blue Cross and Blue Shield of Nebraska created exclusively for State employees.

This article provides you with a brief summary of the **Nebraska Blue*Choice*** plan. It offers you a wide range of benefits and many of the same advantages you've come to rely upon over the years from Blue Cross and Blue Shield.

Here are just a few key points to keep in mind about **Nebraska Blue*Choice:***

- **The Nebraska Blue*Choice* plan uses Blue Cross and Blue Shield of Nebraska's Blue*Preferred* provider network.** This means you have access to a statewide provider network that includes 94% of Nebraska physicians and nearly 100% of all non-governmental acute care hospitals.
- **Traveling outside Nebraska? You're covered! Have covered dependents living in another state? You still have benefits!** Through the BlueCard Program, you and your family members have access to a national Blue Cross and Blue Shield provider network that enables you to receive in-network benefits outside Nebraska. Even though Nebraska Blue*Choice* is not a PPO plan, it utilizes the BlueCard PPO provider network for out-of-state care. The "suitcase" logo on your ID card indicates your plan uses the BlueCard PPO network and enables you to take advantage of the discount and claim filing arrangements Blue Cross and Blue Shield Plans across the country have negotiated with the BlueCard PPO network doctors and hospitals in their area. To find a provider, visit our web site at **www.bcbsne.com**.
- **In-network or out-of-network: It's your choice**. Use network providers and receive the highest level of benefits available to you; however, benefits for covered services are also available at a lower level if you decide to use out-of-network providers.
- **No requirement to designate a Primary Care Physician or obtain referrals**. With Nebraska Blue*Choice*, you have direct access to all network providers, including specialists. You don't have to designate a Primary Care Physician to provide or authorize all your medical care and no referrals are needed to see a specialist.
- **Wellness benefits**. Coverage for routine physical exams, mammograms, immunizations and more.

Special Notes:

1. The out-of-network deductible must be satisfied before out-of-network benefits become available.
2. Blue Cross and Blue Shield of Nebraska must be notified of all medical/surgical inpatient hospital admissions. If the patient is hospitalized in a contracting BluePreferred hospital in Nebraska, notification will be provided by the hospital. If the patient is hospitalized in a non-BluePreferred hospital in Nebraska or is admitted to an inpatient facility in another state, Blue Cross and Blue Shield of Nebraska must be notified. In addition, benefits must be pre-certified for the following inpatient care, regardless of where the care is received, in- or out-of-network: (a) mental illness and/or substance abuse treatment; (b) physical rehabilitation; (c) long term acute care; and (d) skilled nursing facility care. When possible, certification/notification should be completed prior to the inpatient admission. If certification/notification does not take place when required, available benefits for covered services may be reduced by 25%. Benefits for services that are not medically necessary will be denied.
3. Excludes coverage for diabetic and ostomy supplies, which are covered under the State's separate prescription drug benefit.
4. Serious mental illness is defined as any mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person, including the following conditions: schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorder, major depression or obsessive compulsive disorder.

This article provides a brief overview of the deductibles, co-insurance and co-pay amounts under the Blue Cross and Blue Shield of Nebraska–Nebraska BlueChoice health plan offered to State of Nebraska employees. It does not provide a complete description of benefits, limitations, exclusions and other provisions of the master contract to which it refers. This summary provides general information only, and should not be considered to be the master group contract.

Nebraska Blue*Choice*

	In-Network	Out-of-Network [1]
Lifetime maximum	None	$2 million per covered person
Calendar year deductible (The out-of-network deductible must be satisfied before out-of-network benefits are available)	None	$500 / individual $1,000 / family maximum
Maximum out-of-pocket each calendar year (not including deductible, if applicable)	$1,500 / individual $3,000 / family maximum	$3,000 / individual $5,000 / family maximum
Inpatient hospital and approved skilled nursing facility [2]	20% co-insurance	40% co-insurance
Outpatient surgery center (facility fee only)	$50 co-pay	40% co-insurance
Outpatient hospital services (incl. diagnostic lab, x-ray, surgeries, etc)	20% co-insurance	40% co-insurance
Independent diagnostic lab and x-ray facility fee (facility or equipment not owned by the hospital)	No co-pay	40% co-insurance
Physician office visit services / preventive care		
Office visits / consultations / specialist	$15 co-pay	40% co-insurance
Routine physicals	$15 co-pay	40% co-insurance
Annual female exam	$15 co-pay	40% co-insurance
Well baby care	$15 co-pay	40% co-insurance
Maternity (office visit co-pay waived after maternity diagnosis)	$15 co-pay	40% co-insurance
Allergy testing / shots	No co-pay	40% co-insurance
Routine immunizations	No co-pay	40% co-insurance
Surgery	No co-pay	40% co-insurance
Radiology and lab (office)	No co-pay	40% co-insurance
Chemotherapy	No co-pay	40% co-insurance
All other physician services	No co-pay	40% co-insurance
Emergency care services		**Deductible waived, if true emergency*
Ambulance	No co-pay	No co-pay
Urgi-center (minor medical clinic) services	$25 co-pay	$25 co-pay
Hospital emergency room services	$50 co-pay	$50 co-pay
Durable medical equipment [3]	20% co-insurance	20% co-insurance
Routine vision exam (one per calendar year)	No co-pay	Not covered
Outpatient rehabilitation services (Any combination of 60 visits per calendar year) Occupational, physical and speech therapy; chiropractic and osteopathic physiotherapy; spinal manipulations / adjustments	$15 co-pay	40% co-insurance
Home health care and hospice services	No co-pay	40% co-insurance
Organ transplant services	No co-pay	40% co-insurance
Inpatient mental illness and substance abuse treatment [2]	20% co-insurance	50% co-insurance
Benefits (excluding serious mental illness [4]) subject to a 30-day maximum per calendar year		
Outpatient mental illness and substance abuse treatment		
Therapy visits	$20 co-pay	50% co-insurance
Misc. charges (i.e. lab)	20% co-insurance	50% co-insurance
Benefits (excluding serious mental illness [4]) subject to a 60-visit maximum per calendar year		

More information about Nebraska Blue*Choice* will be available at statewide Open Enrollment meetings October 12 through November 21. To find a provider, visit our web site at **www.bcbsne.com**. You can also call Blue Cross and Blue Shield of Nebraska's Customer Service Center in Omaha at **402–548–4615** or Toll Free at **1–800–424–7079**. During Open Enrollment, representatives are available to answer your questions from 7 AM to 7 PM Monday through Friday and Saturdays 8 AM to 12 PM

Nebraska Blue*Select*

This year at Open Enrollment the choices may be new but the name behind them remains the same: Nebraska **Blue*Choice*** and Nebraska **Blue*Select*** were developed exclusively for State employees.

This article provides you with some highlights about Nebraska **Blue*Select*** coverage. This plan offers you a wide range of benefits with an emphasis on wellness.

Here are just a few key points to keep in mind about Nebraska **Blue*Select***:

- **No requirement to designate a Primary Care Physician or obtain referrals.** With Nebraska **Blue*Select***, you have direct access to all network providers, including specialists. You don't have to designate a Primary Care Physician to provide or authorize all your medical care and no referrals are needed to see a specialist.
- **The Nebraska Blue*Select* plan uses Blue Cross and Blue Shield of Nebraska's Blue*Preferred* provider network.** This means you have access to a statewide provider network that includes 94% of Nebraska physicians and nearly 100% of all non-governmental acute care hospitals.
- **Traveling outside Nebraska? You're covered! Have covered dependents living in another state? You still have benefits!** Through the BlueCard Program, you and your family members have access to a national Blue Cross and Blue Shield provider network that enables you to receive in-network benefits outside Nebraska. Even though Nebraska **Blue*Select*** is not a PPO plan, it utilizes the BlueCard PPO provider network for out-of-state care. The "suitcase" logo on your ID card indicates your plan uses the BlueCard PPO network and enables you to take advantage of the discount and claim filing arrangements Blue Cross and Blue Shield Plans across the country have negotiated with the BlueCard PPO network doctors and hospitals in their area. To find a provider, visit our web site at **www.bcbsne.com** .
- **Wellness benefits.** Coverage for routine physical exams, mammograms, immunizations and more.

[1] Blue Cross and Blue Shield of Nebraska must be notified of all medical/surgical inpatient hospital admissions. If the patient is hospitalized in a contracting BluePreferred hospital in Nebraska, notification will be provided by the hospital. If the patient is hospitalized in a non-BluePreferred hospital in Nebraska or is admitted to an inpatient facility in another state, Blue Cross and Blue Shield of Nebraska must be notified. In addition, benefits must be pre-certified for the following inpatient care, regardless of where the care is received, in-or out-of-network: (a) mental illness and/or substance abuse treatment; (b) physical rehabilitation; (c) long term acute care; and (d) skilled nursing facility care. When possible, certification/notification should be completed prior to the inpatient admission. If certification/notification does not take place when required, available benefits for covered services may be reduced by 25%. Benefits for services that are not medically necessary will be denied.

[2] Excludes coverage for diabetic and ostomy supplies, which are covered under the State's separate prescription drug benefit.

[3] Serious mental illness is defined as any mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person, including the following conditions: schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorder, major depression or obsessive compulsive disorder.

This article provides a brief overview of the Srance and co-pay amounts under the Blue Cross and Blue Shield of Nebraska–Nebraska BlueSelect health plan offered to State of Nebraska employees. It does not provide a complete description of benefits, limitations, exclusions and other provisions of the master contract to which it refers. This summary provides general information only, and should not be considered to be the master group contract.

Important note: No benefits are available for out-of-network care under this plan. In Nebraska, services must be obtained from BluePreferred providers. When outside Nebraska, medical care must be obtained from BlueCard PPO providers.

Nebraska Blue*Select*

	In-Network
Lifetime maximum	Unlimited
Calendar year deductible	None
Maximum out-of-pocket each calendar year	$1,500 / individual $3,000 / family
Inpatient hospital and approved skilled nursing facility [1]	20% co-insurance
Outpatient surgery center (facility fee only)	20% co-insurance
Outpatient hospital services (incl. diagnostic lab, x-ray, and outpatient surgery)	20% co-insurance
Independent diagnostic lab and x-ray facility fee (facility or equipment not owned by the hospital)	No co-pay
Physician office visit services / preventive care	
Office visits / consultations / specialist	$15 co-pay
Routine physicals	$15 co-pay
Annual female exam	$15 co-pay
Well baby care	$15 co-pay
Maternity (office visit co-pay waived after maternity diagnosis)	$15 co-pay
Allergy testing / shots	No co-pay
Routine immunizations	No co-pay
Surgery	No co-pay
Radiology and lab (office)	No co-pay
Chemotherapy	No co-pay
All other physician services	No co-pay
Emergency care services	
Ambulance	No co-pay
Urgi–center (minor medical clinic) services	$25 co-pay
Hospital emergency room services	$50 co-pay
Durable medical equipment [2]	20% co-insurance
Routine vision exam (one per calendar year)	No co-pay
Outpatient rehabilitation services (Any combination of 60 visits per calendar year) Occupational, physical and speech therapy; chiropractic and osteopathic physiotherapy; spinal manipulations / adjustments	No co-pay
Home health care and hospice services	No co-pay
Organ transplant services	No co-pay
Inpatient mental illness and substance abuse treatment [1] *Benefits (excluding serious mental illness [3]) subject to a 30-day maximum per calendar year*	20% co-insurance
Outpatient mental illness and substance abuse treatment	
Therapy visits	$20 co-pay
Misc. charges (i.e. lab)	20% co-insurance
Benefits (excluding serious mental illness [3]) subject to a 60-visit maximum per calendar year	

More information about Nebraska Blue*Choice* will be available at statewide Open Enrollment meetings October 12 through November 21. To find a provider, visit our web site at **www.bcbsne.com**. You can also call Blue Cross and Blue Shield of Nebraska's Customer Service Center in Omaha at **402–548–4615** or Toll Free at **1–800–424–7079**. During Open Enrollment, representatives are available to answer your questions from 7 AM to 7 PM Monday through Friday and Saturdays 8 AM to 12 PM

PPO Plan:

A Preferred Provider Option (PPO) Plan is a type of managed care plan that gives you one of the most important options in health care today—the freedom to choose you own physician for any aspect of your care. You will usually encounter less paper work when you see a preferred provider. Preferred providers should submit claim forms for you and indicate in their billing statement that a claim has been filed.

In-Network Preferred Providers:

When you choose a doctor within the PPO network and are seeking care for covered services, benefits are higher (you pay less out-of-pocket). That's because the providers within Mutual of Omaha's network have contracted to provide services at a pre-negotiated rate.

Out-of-Network Providers:

You can choose a provider who is not a preferred provider in Mutual of Omaha's PPO Plan. You are not required to switch to one of our preferred providers. However, your covered benefits will be limited. The deductible, co-insurance and out-of-pocket limits are higher than the In-Network (you pay more out-of-pocket).

Our PPO Plan Offers You…

a wide choice of providers through out the state of Nebraska as well as throughout the country. Access is available in over 300 metropolitan areas. For a complete provider listing, you can view our national provider directory at **www.mutualofomaha.com**. Or you may call the Health Care Service Center to identify an in-network provider in any part of the country.

Important things to know about the Mutual of Omaha PPO Medical Plan:

Mutual of Omaha wants to help you and your family get the highest quality health care possible. This PPO plan, administrative services provided by United of Omaha Life Insurance Company, is designed to provide you well-coordinated medical services, at a reasonable price, through a network of carefully selected providers.

To get the most out of this plan, please remember the following:

1. Pre-certification Requirements—Pre-certification is required whether the provider is In-Network or Out-of-Network. You (or your physician) must initiate pre-certification for all inpatient admissions, certain outpatient surgical procedures, Home Health Care, Hospice Care, Skilled Nursing Facility, Mental and Nervous Disorders / Alcohol and Drug and / or Substance Abuse treatment, Prosthetics and Durable Medical Equipment for purchases of $1,000 or more. For emergency admissions, contact the Plan within 2 days of treatment. You will receive an ID card showing a phone number to use for initiating pre-certification. Penalty for not following the pre-certification requirements is 50% up to $1000.
2. Percentage Payable—The member pays the percentage shown in the Plan Summary and any copay and the calendar year deductible. The Plan pays the amount after the percentage payable.
3. Physician Office Visit Co-payment—When you use a PPO Physician, you will pay a $15 co-payment for each office visit / exam / consultation. This co-payment applies to the office visit / exam / consultation only. All other services you receive (such as x-rays, lab tests, injections, surgeries, etc) will be subject to the calendar year deductible and co-insurance. This co-payment does not apply toward satisfaction of your deductible or co-insurance maximum.
4. Routine Physical Exam / Preventive Care—Routine / Preventive care is a covered service. The Plan will cover the following type of care:
   a. Childhood Immunizations (for children through age 6) up to a calendar year maximum of $200 for each eligible dependent;
   b. Routine Mammography (no age limit) once each calendar year; and
   c. Routine Pap Smear (lab charges only) once each calendar year.

   (Please note it does not pay for Routine Physical Exams and Preventive Exams)
5. Maximum Allowable Amount—Certain Covered Services are subject to a Maximum Allowable Amount. Maximum Allowable Amount means the charge considered for Covered Services before the applicable Deductible and Coinsurance are applied. In cases where the Usual and Customary Charge is less than the Maximum Allowable Amount, the Usual and Customary Charge would apply

Please read your benefits document carefully.

This Plan Summary provides a brief description of some of the features and benefits of your group health plan. This Summary is not a contract. United of Omaha Life Insurance Company complies with Federal and state mandates as dictated by law. The benefits document you will receive will give you a full explanation of your plan's benefits, limitations and exclusions.

Mutual of Omaha, PPO Plan

	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	$400	$600
Family	$800	$1200
Out-of-Pocket Limit (excludes Calendar Year Deductible)		
Individual	$1000	$3400
Family	$2000	$5200
NOTE: The plan pays 100% for most covered services after the out-of-pocket expense is reached.		
Maximum (while covered under the plan except as noted below) NOTE: In-Network and Out-of-Network maximums are combined.	$4,000,000	$4,000,000
Covered Services		
Physician Services		
Office Visits		
– Primary Care Physician	$15 co-pay each visit	30%
– Specialist	$15 co-pay each visit	30%
Allergy Injections	15%	30%
Maternity Services–*includes prenatal, delivery and postnatal physician services*	15%	30%
Surgical Services		
– Inpatient	15%	30%
– Outpatient	15%	30%
Nonsurgical Services	15%	30%
Routine Physical Exam	Not covered	Not covered
Routine Mammogram (no age limit)	15%	30%
Routine Pap Smears (lab test only)	15%	30%
Routine Preventive Care	Not covered	Not covered
Childhood Immunization (through age 6)	no co-pay, deductible waived up to maxium benefit of $200 per calendar year per dependent	no co-pay, deductible waived up to maxium benefit of $200 per calendar year per dependent
Hospital Services		
Room & Board and Services & Supplies	15%	30%
Emergency Care		
Hospital Emergency Room Facility (each visit co-pay waived if admitted to the hospital)	$50 co-pay each visit, deductible waived	$50 co-pay each visit, deductible waived
Urgent Care Center	15%	30%
Ambulance Services	15%, deductible waived	15% , deductible waived

For more information about Mutual of Omaha and services available to members call:
1–800–224–0350
or visit us at
www.mutualofomaha.com
On our web site you will find various Health Education Links, Cost Estimators and much more.

Mutual of Omaha, PPO Plan

Covered Services	In-Network	Out-of-Network
Mental and Nervous (M & N) Disorders		
Outpatient Visit (up to 60 visits each calendar year combined with A & D)	$40 co-pay each visit, deductible waived	$50 co-pay each visit, deductible waived
Outpatient Services (other than therapy visits)	20%	30%
Inpatient Stay (up to 60 visits each calendar year combined with A & D)	20%	40%
Serious Mental Illness		
Outpatient and Inpatient (not subject to calendar year limits)	20%	40%
Alcohol & Drug Abuse and/or Substance Abuse (A & D) (Up to $20,000 plan maximum while insured)		
Outpatient Visit (up to 60 visits each calendar year combined with M & N)	$40 co-pay each visit, deductible waived	$50 co-pay each visit, deductible waived
Outpatient Services (other than therapy visit)	20%	30%
Inpatient Stay (up to 60 visits each calendar year) combined with M & N)	20%	40%
Other Covered Services		
NOTE: In-Network and Out-of-Network maximums and limitations are combined.		
High End Radiology (MRIs, PET Scans, CT Scans, etc)	15%	30%
Independent Radiology and Pathology Center	15%	30%
Outpatient Facility	15%	30%
Outpatient Therapy Services (up to 60 visits each cal year) – Physical & Occupational Therapy – Speech Therapy – Nonsurgical Spinal Treatment	15%	30%
Skilled Nursing Facility (up to 30 days each calendar year)	15%	30%, up to a maximum allowable amount of $200 per day
Home Health Care	15%	30%, up to a maximum allowable amount of $55 per visit
Hospice Care – Inpatient	15%	30%, up to a maximum allowable amount of $55 per visit
– Outpatient	15%	30%, up to a maximum allowable amount of $55 per visit
Durable Medical Equipment	15%	30%, up to a $5,000 plan maximum
Prosthetics	15%	30%, up to a $5,000 plan maximum

For more information about Mutual of Omaha and services available to members call:
1–800–224–0350
or visit us at
www.mutualofomaha.com
On our web site you will find various Health Education Links, Cost Estimators and much more.

HMO & Preferred Provider Network Only Plans

This type of Plan contracts with selected doctors, hospitals, and other medical providers to form a health care system that can offer all the medical services most people may need. As a member, you agree to receive your medical care from the providers in that health care system. In return, the providers coordinate with one another to help meet your health care needs and provide quality care.

Important things to know about the Mutual of Omaha HMO / Network Only Medical Plan:

Mutual of Omaha wants to help you and your family get the highest quality health care possible. This plan's administrative services are provided by Exclusive Health care, Inc. / United of Omaha Life Insurance Company, The plan is designed to provide you well-coordinated medical services, at a reasonable price, through a network of carefully selected providers.

To get the most out of this plan, please remember the following:

1. **Out-of-Network Care**—In the event that specific Covered Services cannot be provided by a network provider and you see an out-of-network provider, you still may be eligible for benefits. All out-of-network services (except medical emergencies) must be authorized / pre-certified in advance of any treatment by calling the Customer Service number shown on your ID card. If advance authorization / pre-certification is not obtained prior to care, benefits will be denied.
2. **Percentage Payable**—The member pays the percentage shown in the Plan Summary and any co-pay and the calendar year deductible. The Plan pays the amount after the percentage payable.
3. **Physician Office Visit Co-payment—**The Physician Office Visit co-payment is for services received in the Physician's office includes, but is not limited to:
   a. services other than surgery:
      - office visits;
      - consultations;
      - ophthalmology exam, and
      - Medical Emergency office visits;
   b. injections (excluding Specialty Pharmacy Drugs and Medicines);
   c. allergy testing;
   d. radiation therapy; and
   e. x-ray and laboratory services (excluding other High End Radiology, such as MRIs, CT scans, PET scans, SPECT scans, arteriograms and other nuclear medical scans).

The Covered Office Visit Services do **not** include:

   a. services performed by any other provider;
   b. office surgery;
   c. outpatient therapy;
   d. treatment for Mental and Nervous Disorders / Alcohol and Drug Abuse and / or Substance Abuse.

4. **Routine Physical Exam / Preventive Care**—Routine / Preventive care is a covered service. The Plan will cover the following types of care:
   a. Routine physical exam (for those age 18 and older), including routine gynecological exam and immunizations performed in a Hospital outpatient department, or Physician's office or clinic;
   b. Preventive health care (for children through age 17) services from a Physician (other than Childhood Immunization Services) performed in a Hospital outpatient department, or Physician's office or clinic;
   c. Immunizations
   d. Routine Mammography (no age limit) once each calendar year;
   e. Routine Pap Smears once each calendar year; and
   f. Routine Colonoscopies and Sigmoidoscopies.
5. **Pre-certification Requirements—**Pre-certification is required whether the provider is In-Network or Out-of-Network. You (or your physician) must initiate pre-certification for all inpatient admissions, certain outpatient surgical procedures, Home Health Care, Hospice Care, Skilled Nursing Facility, Mental and Nervous Disorders / Alcohol and Drug and / or Substance Abuse treatment, Prosthetics, Durable Medical Equipment for purchases of $1,000 or more and any out-of-network care. For emergency admissions, contact the Plan within 2 days of treatment. You will receive an ID card showing a phone number to use for initiating pre-certification. Penalty for not following the pre-certification requirements is $300.
6. **Primary Care Physician** (PCP)—With this benefit option, you will select a PCP to help coordinate your care. All members must have a PCP, so if family members are joining with you, you will need to select a PCP for them too. No referrals are needed. That means you can self refer to a specialist or seek care from any provider without a PCP referral. Some geographical areas do not require PCP selections (see locations on page 18).

For more information about Mutual of Omaha and services available to members call **1–800–224–0350** or visit us at **www.mutualofomaha.com** On our web site you will find various Health Education Links, Cost Estimators and much more.

Mutual of Omaha, HMO & Preferred Provider Network Only Plans

Benefit Level	
Calendar Year Deductible	
Individual	Not Applicable
Family	Not Applicable
Out-of-Pocket Limit:	
Individual	$1500
Family	$3000
Maximum (while covered under the plan except as noted below)	Unlimited
Covered Services	**Pay % shown**
Physician Services	
Office Visits	
– Primary Care Physician	$15 co-pay each visit
– Specialist	$15 co-pay each visit
Allergy injections	No co-pay
Maternity Services, pre-natal and post-natal physician services *(office visit co-pay waived after maternity diagnosis)*	No co-pay
Surgical Services	
– Inpatient	No co-pay
– Outpatient (includes office surgery)	No co-pay
Nonsurgical Services–Inpatient and Outpatient	No co-pay
Routine Physical Exam (age 18 or older)	
– Primary Care Physician	$15 co-pay each visit
– Specialist	$15 co-pay each visit
Routine Mammograms (no age limit)	No co-pay
Routine Pap Smears (lab test only)	No co-pay
Adult Immunizations (age 7 or older)	No co-pay
Routine Preventive Care (through age 17)	
– Primary Care Physician	$15 co-pay each visit
– Specialist	$15 co-pay each visit
Childhood Immunization Services (through age 6)	No co-pay
Hospital Services	
Room & Board and Services & Supplies	20%
Emergency Care	
Hospital Emergency Room (each co-pay, waived if admitted to the hospital)	$50 co-pay each visit
Urgent Care Center	$25 co-pay each visit
Ambulance Services	No co-pay
Mental or Nervous Disorders	
Outpatient Visit (up to 60 visits each calendar year)	$20 co-pay each visit,
Outpatient Services (other than therapy visit)	20%
Inpatient Stay (up to 30 days each calendar year)	20%
Serious Mental Illness	
Outpatient (visit limits do not apply)	$20 co-pay each visit
Inpatient (visit limits do not apply)	20%
Alcohol & Drug and/or Substance Abuse	
Outpatient Visit (up to 60 visits each calendar year)	$20 co-pay each visit
Outpatient Services (other than therapy visit)	20%
Inpatient Stay (up to 30 days each calendar year)	20%

Mutual of Omaha, HMO & Preferred Provider Network Only Plans

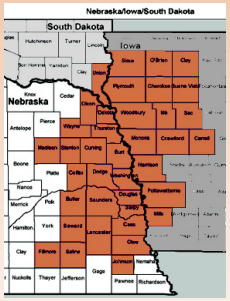
Covered Services	Pay % shown
Other Covered Services	
High End Radiology (MRIs, PET Scans, CT Scans and other nuclear radiology scans)	20%
Independent Radiology and Pathology	No co-pay
Outpatient Facility	
– Surgical	20%
– Non Surgical	20%
Outpatient Therapy Services (up to 60 visits each cal year)	$15 co-pay each visit,
– Physical & Occupational Therapy	
– Speech Therapy	
– Nonsurgical Spinal Treatment	
Skilled Nursing Facility	20%
Home Health Care	No co-pay
Hospice Care	
– Inpatient	No co-pay
– Outpatient	No co-pay
Durable Medical Equipment	20%
Prosthetics	20%
Routine Vision Care	
One Spectacle Exam each calendar year	No co-pay

If you live in the following counties you will need to select a Primary Care Physician (PCP). To determine the PCP in your area you can obtain a directory on line at **www.mutualofomaha.com** and select the HMO/POS directories.

Nebraska: Burt, Butler, Cass, Colfax, Cuming, Dakota, Dixon, Dodge, Douglas, Fillmore, Johnson, Lancaster, Madison, Otoe, Saline, Sarpy, Saunders, Seward, Stanton, Thurston, Washington, and Wayne.

Iowa: Buena Vista, Carroll, Cherokee, Clay, Crawford, Harrison, Ida, Mills, Monona, O'Brien, Plymouth, Pottawattamie, Sac, Sioux, and Woodbury.

If you do not live in the above counties you do not need to select a PCP. To determine the providers in your area you can obtain a directory on line at www.mutualofomaha.com and select the Medical/PPO directories.



For more information about Mutual of Omaha and services available to members call **1–800–224–0350** or visit us at **www.mutualofomaha.com** On our web site you will find various Health Education Links, Cost Estimators and much more.

Point-of-Service Plan:

A Point-of-Service (POS) Plan is a type of managed care plan that gives you a choice of two levels of benefits (in-network and out-of-network) any time you need care. When you are covered by a POS plan, your out-of-pocket costs vary according to how you choose to receive medical care.

In-Network Care:

With this benefit option, you will select a Primary Care Physician (PCP) to help coordinate your care. However, you can seek medical care from any network provider. That means you can self refer to a specialist or seek care from a provider other than your PCP without a PCP referral. You will have lower out-of-pocket costs if you stay in-network when seeking medical care.

Out-of-Network Care:

With a POS plan, you always have the option to see a provider outside the provider network and still be eligible for benefits. These benefits are payable at a lower benefit level (you pay more out-of-pocket).

Important things to know about the Mutual of Omaha POS Medical Plan:

Mutual of Omaha wants to help you and your family recieve the highest quality health care possible. This POS plan's administrative services are provided by Exclusive Healthcare, Inc./United of Omaha Life Insurance Company. The plan is designed to provide you well-coordinated medical services, at a reasonable price, through a network of carefully selected providers.

1 **Percentage Payable—**The member pays the percentage shown in the Plan Summary and any co-pay and the calendar year deductible. The Plan pays the amount after the percentage payable.

2 **Physician Office Visit Co-payment**—The Physician Office Visit co-payment for services received in the Physician's office includes, but is not limited to:
- a services other than surgery:
  - office visits;
  - consultations;
  - Ophthalmology exam, and
  - Medical Emergency office visits;
- b injections (excluding Specialty Pharmacy Drugs and Medicines;
- c allergy testing;
- d radiation therapy; and
- e x-ray and laboratory services (excluding other High End Radiology, such as MRIs, CT scans, PET scans, SPECT scans, arteriograms and other nuclear medical scans).

The Covered Office Visit Services do **not** *include*:
- a services performed by any out-of-network provider;
- b office surgery;
- c outpatient therapy;
- d treatment for Mental and Nervous Disorders/Alcohol and Drug Abuse and/or Substance Abuse.

3 **Routine Physical Exam/Preventive Care**—Routine/Preventive care is a covered service. The Plan will cover the following types of care:
- a Routine physical exam (for those age 18 and older), including routine gynecological exam and immunizations performed in a Hospital outpatient department; or Physician's office or clinic;
- b Preventive health care (for children through age 17) services from a Physician (other than Childhood Immunization Services) performed in a Hospital outpatient department; or Physician's office or clinic;
- c Childhood Immunizations (for children through age 6)
- d Routine Mammography (for any age) once each calendar year;
- e Routine Pap Smears once each calendar year; and
- f Routine Colonoscopies and Sigmoidoscopies.

4 **Maximum Allowable Amount**—Certain Covered Services are subject to a Maximum Allowable Amount. Maximum Allowable Amount means the charge considered for Covered Services before the applicable Deductible and Coinsurance are applied. In cases where the Usual and Customary Charge is less than the Maximum Allowable Amount, the Usual and Customary Charge would apply.

5 **Pre-certification Requirements—**Pre-certification is required whether the provider is In-Network or Out-of-Network. You (or your physician) must initiate pre-certification for all inpatient admissions, certain outpatient surgical procedures, Home Health Care, Hospice Care, Skilled Nursing Facility, Mental and Nervous Disorders/Alcohol and Drug and/or Substance Abuse treatment, Prosthetics, Durable Medical Equipment for purchases of $1,000 or more and any out-of-network care. For emergency admissions, contact the Plan within 2 days of treatment. You will receive an ID card showing a phone number to use for initiating pre-certification. Penalty for not following the pre-certification requirements is $300.

6 **Primary Care Physician** (PCP)—With this benefit option, you will select a PCP to help coordinate your care. All members must have a PCP, so if family members are joining with you, you will need to select a PCP for them too. No referrals are needed. That means you can self refer to a specialist or seek care from any provider without a PCP referral. Some geographical areas do not require PCP selections (see locations on page 21).

Please read your benefits document carefully.

This Plan Summary provides a brief description of some of the features and benefits of your group health plan. This Summary is not a contract. Exclusive Health care, Inc./United of Omaha Life Insurance Company comply with Federal mandates as dictated by law. The benefits document you will receive will give you a full explanation of your plan's benefits, limitations and exclusions.

Mutual of Omaha, POS

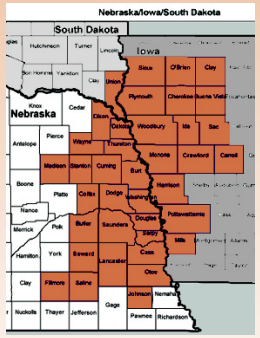
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	Not applicable	$500
Family	Not applicable	$1000
Out-of-Pocket Limit		
(excludes Calendar Year Deductible)		
Individual	$1500	$3000
Family	$3000	$5000
NOTE: The plan pays 100% for most covered services after the out-of-pocket expense is reached.		
Maximum (while covered under the plan except as noted below)	Unlimited	$2,000,000
NOTE: In-Network and Out-of-Network maximums are combined.		
Covered Services	**In-Network**	**Out-of-Network**
Physician Services		
Office Visits		
– Primary Care Physician	$15 co-pay each visit	40%
– Specialist	$15 co-pay each visit	40%
Allergy Injections	No co-pay	40%
Maternity Services–includes prenatal, delivery and postnatal physician services (office visit co-pay waived after maternity diagnosis)	No co-pay	40%
Surgical Services		
– Inpatient	No co-pay	40%
– Outpatient (includes office surgery)	No co-pay	40%
Nonsurgical Services–Inpatient and Outpatient	No co-pay	40%
Routine Physical Exam (age 18 or older)		
– Primary Care Physician	$15 co-pay each visit	40%
– Specialist	$15 co-pay each visit	40%
Adult Immunizations (age 7 or older)	No co-pay	40%
Routine Mammograms (no age limit)	No co-pay	40%
Routine Pap Smears (Lab charges only)	No co-pay	40%
Routine Preventive Care (through age 17)		
– Primary Care Physician	$15 co-pay each visit	40%
– Specialist	$15 co-pay each visit	40%
Childhood Immunization (through age 6)	No co-pay	40%
Hospital Services		
Room & Board and Services & Supplies	20%	40%

If you live in the following counties you will need to select a Primary Care Physician (PCP). To determine the PCP in your area you can obtain a directory on line at **www.mutualofomaha.com** and select the HMO/POS directories.

Nebraska: Burt, Butler, Cass, Colfax, Cuming, Dakota, Dixon, Dodge, Douglas, Fillmore, Johnson, Lancaster, Madison, Otoe, Saline, Sarpy, Saunders, Seward, Stanton, Thurston, Washington, and Wayne.

Iowa: Buena Vista, Carroll, Cherokee, Clay, Crawford, Harrison, Ida, Mills, Monona, O'Brien, Plymouth, Pottawattamie, Sac, Sioux, and Woodbury.

If you do not live in the above counties you do not need to select a PCP. To determine the providers in your area you can obtain a directory on line at www.mutualofomaha.com and select the Medical/PPO directories.



For more information about Mutual of Omaha and services available to members call **1–800–224–0350** or visit us at **www.mutualofomaha.com**. On our web site you will find various Health Education Links, Cost Estimators and much more.

Mutual of Omaha, POS

Covered Services	In-Network	Out-of-Network
Emergency Care		
Hospital Emergency Room (each visit co-pay waived if admitted to the hospital)	$50 co-pay each visit	$50 co-pay each visit, deductible waived
Urgent Care Center	$25 co-pay each visit, deductible waived	$25 co-pay each visit,
Ambulance Services	No co-pay	No co-pay, deductible waived
Mental or Nervous Disorders		
Outpatient Visit (up to 60 visits each calendar year)	$20 co-pay each visit	50%
Outpatient Services (other than therapy visit)	20%	50%
Inpatient Stay (up to 30 days each calendar year)	20%	50%
Serious Mental Illness		
Outpatient	$20 co-pay each visit	50%
Inpatient (visit limits do not apply)	20%	50%
Alcohol & Drug Abuse and/or Substance Abuse		
Outpatient Visit (up to 60 visits each calendar year)	$20 co-pay each visit	50%
Outpatient Services (other than therapy visit)	20%	50%
Inpatient Stay (up to 30 days each calendar year)	20%	50%
Other Covered Services		
NOTE: *In-Network and Out-of-Network maximums and limitations are combined.*		
High End Radiology (MRIs, PET Scans, CT Scans, etc)	20% if hospital or no co-pay if Independent Radiology	40%
Independent Radiology and Pathology	No co-pay	40%
Outpatient Facility		
– Surgical—Free standing facility	$50 co-pay each visit	40%
– Surgical—hospital facility	20%	40%
– Non-Surgical	20%	40%
Outpatient Therapy Services (up to 60 visits each cal year)	$15 co-pay each visit	40%
– Physical & Occupational Therapy		
– Speech Therapy		
– Nonsurgical Spinal Treatment		
Skilled Nursing Facility	20%	40%, up to a maximum allowable amount of $200 per day
Home Health Care	No co-pay	40%, up to a maximum allowable amount of $55 per visit
Hospice Care		
– Inpatient	No co-pay	40%, up to a maximum allowable amount of $55 per day
– Outpatient	No co-pay	40%, up to a maximum allowable amount of $55 per visit
Durable Medical Equipment	20%	20%, up to a $5,000 plan maximum
Prosthetics	20%	40%, up to a $5,000 plan maximum
Routine Vision Care	No co-pay	Not covered
Routine Eye Exam (one spectacle exam each calendar year)		

For more information about Mutual of Omaha and services available to members call **1–800–224–0350** or visit us at **www.mutualofomaha.com**. On our web site you will find various Health Education Links, Cost Estimators and much more.

New Insurance Option for Military TRICARE Eligible State Employees and Their Families

Beginning October 12 through November 21, 2004, you'll have the opportunity to enroll yourself and your eligible dependents in the ASI TRICARE Supplement. Eligible employees must cancel their Nebraska State primary insurance coverage to enroll in the TRICARE Supplement plan.

Who is eligible?

Eligible State of Nebraska employees (including non-Medicare retirees) or a State of Nebraska employee's spouse must be:

- Military retirees under age 65, their spouses or surviving spouses under age 65 and their unmarried, dependent children under age 21 or 23 if a full-time student;
- Retired reservists, Guardsmen and their families, if the reservist is age 60 or older and has at least 20 creditable years of military service;
- Registered with the Defense Enrollment Eligibility Reporting System (DEERS) and entitled to retired, retainer or equivalent pay.

What is the TRICARE Supplement plan?

The TRICARE Supplement plan provides TRICARE beneficiaries additional coverage that pays 100 % of the member's out-of-pocket covered costs.

Some of the plan's features include:

- No pre-existing condition exclusions
- No plan deductibles or out-of-pocket expenses for covered services
- Freedom of choice—you can choose to see any TRICARE authorized civilian doctor or specialist
- Portability—you may take the coverage with you wherever you go
- Pharmacy benefit (retail and mail order)
- Guaranteed issue—all eligible employees may enroll.

Important enrollment reminders:

- The TRICARE Supplement plan is only available to active employees and non-Medicare retirees.
- When you change from the NSIP to the TRICARE Supplement plan, you must notify TRICARE by completing the required forms (other health insurance form).
- Your DEERS eligibility record must be current for each family member.
- Upon enrollment you will receive a packet with your certificate of insurance, identification card, claim forms and instructions on how to file claims.
- You can switch back to the NSIP only during the next open enrollment period (2005) or with a qualified family status change.

TRICARE Benefits with the Supplement

Deductible	
Employee	$0
Family	$0
Cost Share or Co-insurance	
In-Network	$0
Out-of-Network	$0
Prescription Co-pay	
Generic	$0
Brand	$0

Tricare Supplement Cost

Employee only	12.60
Employee + 1 Dependent*	25.00
Employee + 2 Dependents*	33.60

**Dependent can be a spouse and / or child*

The TRICARE Supplement plan will be offered to State of Nebraska TRICARE eligible employees as an alternative choice to the Nebraska State Insurance Program (NSIP).

TRICARE is a medical plan provided by the Department of Defense.

For more information on the TRICARE Supplement plan, contact your agency HR representative.
or
visit:
www.neemployee43.absmil.net

The State of Nebraska is pleased to announce a partnership with Walgreens Health Initiatives (WHI) to provide Nebraska's Prescription Drug Card Program effective January 1, 2005.

Retail Pharmacy

The WHI retail pharmacy benefit allows you to obtain covered prescriptions for up to a 30-day supply from a nationwide network of more than **55,000 pharmacies**, including Walgreens, Costco, Kmart, Kroger, Target and Wal-Mart. Pharmacies can be identified by calling WHI Member Services at **1–800–207–2568** or by simply entering your zip code via the web site pharmacy locator at **www.mywhi.com**.

Home Delivery

You can receive a 180-day supply by using Walgreens Healthcare Plus Home Delivery. WHI suggests that you request two prescriptions from your doctor. One prescription is to obtain the initial 30-day supply from a retail pharmacy. The second prescription, which you will send to the mail service facility, should be written for a 180-day supply with one refill.

180-Day Supply at RETAIL

In addition to being able to receive maintenance medications from Walgreens Healthcare Plus Home Delivery, you will also have the option, choice and convenience to purchase a 180-day supply at select participating network pharmacies (select network pharmacies to be announced prior to 01/01/2005). Your 180-Day Supply co-pays will be the same as Mail.

Other Important Information…

- **WHI prescription drug cards** will be issued before the January 1st effective date. You will need to present your new card to your pharmacy to make them aware of your new provider.
- No change in cost—the co-pays for your prescriptions will remain at $27.00 for each 30-day supply at a retail pharmacy for brand drugs and $11.00 for generic drugs. Home Delivery will remain $62.91 for brand drugs and $25.63 for generic drugs, which will reflect a 180-day supply.
- Prior Authorization (PA)—some medications require a prior authorization by the Plan. Should you be prescribed a medication that requires a PA, your pharmacy will inform you.
- A one-time set up for Home Delivery prescriptions will be required. Included in the mailing when you receive your new prescription drug benefit card, you will also receive a brochure-sized form called "Mail Service Pharmacy-Order Form". Please follow the directions provided to get your mail order prescription set up for the first time with WHI.
- Effective January 1, 2005 you can visit **www.mywhi.com** to check drug coverages and co-pays, find generic alternatives, review your prescription history, confirm eligibility, register for Mail Home Delivery and order refills online, print a temporary ID card and search for a nearby pharmacy.

There is no need to enroll in this benefit. It is automatic when you enroll in a BCBS or Mutual health plan. There is no additional premium for this benefit beyond your medical insurance premium.

Walgreen Health Initiative rates

	Generic	Brand Name
up to 30-day supply	$11.00	$27.00
180-day supply	25.63	62.91
mail service 180-day supply	25.63	62.91

This letter is intended to provide you with advance notice of this transition. Additional information to follow in the coming months.

Pharmacies can be identified by calling WHI Member Services at **1–800–207–2568** or by simply entering your zip code via the web site pharmacy locator at **www.mywhi.com**.

FORTIS BENEFITS' long-term disability coverage provides a tax-free monthly income benefit should you become disabled and are unable to work due to injury or illness.

COST

The cost is based on the option you choose, your age and your salary. Follow the simple steps below to determine your exact monthly cost.

1. Enter your basic monthly pay (not including overtime) $ _____
2. Enter rate for your age and option you select X _____
3. Multiply (#1) x (#2). = [ ] *(This is your exact monthly cost.)*

If you are paid bi-weekly, one half of this amount will be deducted each pay period.

The ***Qualifying Period*** is the amount of time you must be disabled before benefits start.

The ***Schedule Amount*** is the maximum of monthly benefit payable not to exceed $7,500

			Age at January 1 of 2005		
	Qualifying Period	**Schedule Amount**	**UNDER 40**	**40–49**	**50 & Over**
OPTION 1	3 months	60% of your monthly pay from the State	0.0056	0.0107	0.0143
OPTION 2	6 months	60% of your monthly pay from the State	0.0034	0.0063	0.0083
OPTION 3	9 months	60% of your monthly pay from the State	0.0029	0.0054	0.0071
OPTION 4	4 months	50% of your monthly pay from the State	0.0027	0.0044	0.0060
OPTION 5*	2 months	66 2/3% of your monthly pay from the State	0.0085	0.0162	0.0216
OPTION 6*	6 months	66 2/3% of your monthly pay from the State	0.0055	0.0101	0.0133

* These options are no longer available. However, if you are currently enrolled in Option 5 or 6, you do not need to change options, unless you choose to do so.

This is a very brief description of the plan. Please obtain a brochure from your agency personnel department or an open enrollment meeting for a complete description. The terms of the master policy issued to the State of Nebraska governs all provisions.

Fortis (Long Term Disability)
1–800–998–7858 ext. 6082

Mutual of Omaha will provide Basic, Supplemental and Dependent Life Insurance, in addition to Accidental Death and Dismemberment Insurance, to all State of Nebraska employees. There is no change in the rates or coverage from last year. The $20,000 Basic Life Benefit is available to eligible full-time employees at no cost, and eligible part-time employees for a minimal monthly charge. For minimal contribution, employees can select one of two Dependent Life options, one of four Supplemental Life plans and/or the optional Accidental Death and Dismemberment benefits.

Benefits & Rates for Employees

Basic Life

Benefits	$20,000.00
Monthly Rate per $1,000	
Class 01 & 03: All other active employees	$0.14
Class 2: All NDOL employees	$0.13
Class 4: NDOL retirees	$0.15

Supplemental Life (choose one only)

Benefits	
Flat	$5,000.00
1 x Annual Salary	
2 x Annual Salary	
3 x Annual Salary	

(Amounts are rounded to the next highest $1,000)

Monthly rates per $1,000 of Supplemental Life are based upon your attained age.

Under 30	$0.07	55–59	$0.60
30–34	$0.08	60–64	$0.90
35–39	$0.11	65–69	$1.47
40–44	$0.13	70–74	$2.00
45–49	$0.20	75–79	$4.54
50–54	$0.31	80 & Over	$9.19

Supplemental Life insurance benefits reduce as follows:

If you are age:	*Your benefit will be reduced to:*
70–74	*70.00%*
75–79	*47.50%*
80–84	*32.00%*
85–89	*22.50%*
90 and over	*15.00%*

Benefits & Rates for Dependents

Optional Dependent Life (Choose only one)

Low Option 1:	
Spouse	*$5,000.00*
Children	
3 days, but less than 6 months	*$2,000.00*
6 months to 19 years (24 if full-time student)	*$3,000.00*
Monthly cost per family	*$2.11*
Dependent age 70 or older	*$5.66*

High Option 2:	
Spouse	*$10,000.00*
3 days, but less than 6 months	*$2,500.00*
6 months to 19 years (24 if full-time student)	*$5,000.00*
Monthly cost per family	*$4.13*
Dependents age 70 or older	*$11.32*

Beneficiary

You may name anyone as your beneficiary. You must file the name(s) at the office of the Policyholder on a form approved by Mutual of Omaha.

You may change your beneficiary at any time by giving notice in writing. The effective date of the change is the date the request is signed. However, Mutual of Omaha is not liable for any amount paid before the request is received.

Important Note: During open enrollment, you may increase your amount of coverage by ONE increment without submitting proof of good health. However, if you elect to increase your coverage by more than one increment, you must submit evidence of good health, acceptable to Mutual of Omaha.

Mutual of Omaha (Life)
1–800–775–8805 (claims only)

ACCIDENTAL DEATH AND DISMEMBERMENT

If you elect Accidental Death and Dismemberment (AD&D) coverage, Mutual of Omaha will pay a benefit if you are injured as a result of an accident, and that injury is independent of sickness and all other causes. There is no change in the rates or coverage from last year. The loss must occur within 90 days of the date of the accident, and you must be covered under the Plan on the date of the accident. AD&D benefits are based on a "Principal Sum," which is $5,200.00 for (Class 001) all other eligible State of Nebraska employees and all (Class 003) eligible Law Enforcement Bargaining unit employees. Rate—$0.10

Principal Sum = one times salary to a maximum of $60,000 for (Class 005) all eligible Nebraska Department of Labor active employees who elected to participate in the plan prior to 7/1/91. Rates per $1,000 = $0.019.

The AD&D benefit is dependent upon the type of loss you suffer, and is either a portion or all of the Principal Sum (Principal Sum defined previously), as shown in the table below. The benefit for loss of life will be paid to your beneficiary, and all other benefits will be paid to you.

Class 001 & 003: All other eligible State of Nebraska employees and all eligible Law Enforcement Bargaining unit employees (Rate: $0.10).

Class 005: all eligible Nebraska Department of Labor active employees who elected to participate in the plan prior to 7/1/91. Rates per $1,000 = $0.019.

AD&D Benefit Table

Type of Loss	Benefit
Life Both Hands Both Feet Entire Sight of Both Eyes One Hand and One Foot One Hand and Entire Sight of One Eye One Foot and Entire Sight of One Eye Speech and Hearing (both ears) [Quadriplegia] (Paralysis of all four limbs.)	Principal Sum
Triplegia (Paralysis of an upper and lower extremity and of the face, or of both extremities on one side and of one on the other.)	Three-quarters Principal Sum
Entire Sight of One Eye Speech and Hearing (both ears) One Hand or One Foot Paraplegia (Paralysis of both lower extremities and the lower trunk.) Hemiplegia (Paralysis of one side of the body)	One-half Principal Sum
Loss of Thumb & Index Finder of same Hand Uniplegia (Paralysis of one part of the body)	One-fourth Principal Sum

Mutual of Omaha (Life)
1–800–775–8805 (claims only)

Continuation of All Eligible Benefits

COBRA is a federal law allowing the continuation of health / dental / vision / EAP / Medical Flex benefits for any employee or dependent who would otherwise lose group coverage due to a qualifying event.

Qualifying Event:

A qualifying event is the date that an event occurs for an employee or dependent (i.e., employee terminates employment, dependent quits school, turns age 19 and is no longer a full-time student, turns age 24, less than full-time student, etc.). Existing insurance is always carried to the end of the month in which the qualifying event occurs.

Eligible Employees:

If your employment with the State is terminated or your work hours are reduced below 20 hours per week, and you were covered by a State plan, you become eligible for COBRA for up to 18 months (29 months for disabled employees if not eligible for disability retirement from the State).

Eligible Family Members:

Certain family members also have the option to continue all eligible benefits after the benefits would normally cease. Family members who have a qualifying event can continue the eligible benefits for up to a maximum of 18 to 36 months.

Family members are eligible for 18 months of coverage, if the following occurs:

- Employee's termination;
- Reduction in employee's hours of employment to less than 20 hours per week.

Family members (spouse or dependent children) are eligible for up to 36 months of coverage, if the following occurs:

- Death of the employee;
- Divorce involving an employee (upon completion of Nebraska's six-month waiting period for insurance benefits) or legal separation (as granted by a judge);
- Employee becomes entitled to Medicare benefits;
- Child ceases to be an eligible dependent (reaches 19th birthday and is no longer a full-time student, marries, quits school, obtains full-time employment (this does not mean full-time work through summer months or temporary jobs), or reaches 24th birthday).

Under COBRA Law, the employee or a family member has the responsibility to inform his or her agency's HR representative of a divorce, or a child losing dependent status, under the employee's present carrier within 60 days of the date of the event.

Early Retirees' Program / Disability Retirement

This program was created for state employees who retire under the State of Nebraska Retirement System. The program allows a retiree the option of continuing all eligible benefits until the first of the month in which they turn 65, or until they start to receive Medicare part A or part B, if prior to age 65.

Eligibility of Employee:

- Employees who retire, including those who retire due to disability and are eligible for State's retirement, may continue in the plan.

Eligibility of Family Members:

- Family members of a retired state employee are eligible for continuation of the retiree's health insurance coverage until they reach age 65 or the employee reaches age 65, whichever occurs first.
- If a family member reaches age 65 before the employee, the family member is ineligible to continue coverage through the retiree program. Contact the insurer for information about conversion options.
- If the retiree reaches age 65 before the dependents, the dependents are allowed to continue their coverage through the COBRA program for a period not to exceed 36 months or until the age of 65, whichever comes first.

Disability Retirement

An employee under age 55 may retire as a result of a disability. You will need to contact the Retirement System on how to apply for this. An employee who chooses this option must first elect COBRA and once he or she is approved, the Retirement System will notify the State Health and Life Section, DAS State Personnel Benefits. The individual's coverage will be converted to the Early Retiree Health Plan until he / she reaches age 65, or until he or she starts to receive Medicare part A or part B.

For more information on COBRA contact DAS State Personnel Benefits
402–471–3315

Confidential Counseling Solutions:

A Benefit for You

Everyone, at one time or another, experiences ups and downs, peaks and valleys. Sometimes, this roller coaster of emotion becomes too great to continually sustain. You may feel you need someone to talk to…someone who can understand and offer supportive help.

Best Care EAP, a service of Methodist Health System, is a short-term counseling service to help you and your family begin to work through personal problems, such as marital conflicts, grief issues, stress, substance abuse, parenting issues, plus more.

Why was the program established?

Modern living places new problems and greater demands on people. Sometimes, personal problems are hard to leave at home and begin to surface in the workplace. When this happens, it is essential that professionally trained counselors are available to provide needed assistance.

The philosophy of Best Care EAP is that nearly every human problem can be successfully handled, once it is recognized and assistance is provided. Therefore, this program provides the opportunity for you to identify and resolve personal problems that adversely affect self-esteem, family life, relationships and/or your job.

Who will know?

When you use the services of Best Care EAP, you are assured of absolute confidentiality. If you directly contact a Best Care EAP counselor, no one will know. All sessions are confidential, a critical element in Best Care EAP's success. Information is not released without your written permission.

What help is available?

You and your family can discuss personal problems openly and confidentially with a licensed, professional counselor in a comfortable and relaxed setting. The counselor will help provide an objective viewpoint and guide you and family members toward potential solutions.

What is the cost?

Best Care EAP services are a free benefit from the State of Nebraska. In some cases, the help of a community resources agency may be needed. If so, the counselor will refer you to the most appropriate resource. When a referral is made, those expenses become your responsibility.

How can I get help?

To arrange for a private and confidential appointment, call **402–354–8000** or **1–800–666–8606**, or, if no answer, call **402–354–2710**.

For more information check the web site at:
www.BestCareEAP.org

Office hours are:

Monday through Thursday	8:00 AM–8:30 PM
Friday	8:00 AM–4:30 PM
Saturday	8:00 AM–1:00 PM

Crisis and Emergency services are available after hours.

Office hours are:

Monday through Thursday:
8:00 AM–8:30 PM

Friday:
8:00 AM–4:30 PM

Saturday:
8:00 AM–1:00 PM

Crisis and Emergency services are available after hours.

How can I get help?
To arrange for a private and confidential appointment, call **402–354–8000** or **1–800–666–8606**, or, if no answer, call **402–354–2710**.

For more information check the web site at:
www.BestCareEAP.org

What steps can I take to ensure I successfully complete the Open Enrollment event?

a. *If you haven't already, log in to the system to make sure you have access to the ESS menus.*
b. ***Start early**—Learn the navigation of the Open Enrollment Process either through Web Based Training, Agency Training, or Logging directly into Open Enrollment. You will have from October 12, 2004 until November 21, 2004 to make your 2005 elections.*
c. *Complete the Employee Benefits Open Enrollment worksheet included in this publication.*
d. *Print a copy of your Current Elections in order to compare 2004 benefits to 2005 elections.*
e. *If you do not click the "I accept" button and receive a transaction number before you leave the enrollment site, your elections have not been saved.*
f. *Print the confirmation statement with the transaction number.*

What does it mean when I click "I accept"?

Clicking on "I accept" represents electronic legal signature and proof that you completed the Open Enrollment process.

How long will it take me to enroll for my 2005 benefits through the Employee Self Service process?

Approximately 30 minutes.

What happens if I am interrupted during the Open Enrollment process? Will my changes be saved?

No. Your changes will only be saved when you have clicked "I accept", and received a Final Confirmation Statement with a transaction number.

Will the system "time out" during the Open Enrollment process?

Yes. If you leave the Open Enrollment process **inactive** *for 30 minutes, the system will log you out automatically. If you clicked the "I accept" button and received a Final Confirmation Statement with a transaction number, your enrollment has sucessfully been completed. If you do not click the "I accept" button and receive a transaction number, you will lose what was entered and will need to start over.*

If I do not have a tax ID number (Social Security number) for my newborn dependent, what should I enter?

Use nine 1's (with no dashes). Once the IRS has sent you the Social Security number, contact your agency Human Resource staff to update your records.

How can I change the text size on my personal computer for the Open Enrollment Event?

Once you enter the Open Enrollment event, click on View, then Text Size on your browser menu bar, and choose the size you prefer.

Can I use the "back buttons" found on the tool bar of my personal computer?

No. Click on the "Previous", "Next", or "Exit" buttons found in the Open Enrollment event screens.

Can I use the "x" in the right hand corner of the screen to close out of the NIS system?

No. Use the "Exit" button if you are in the Open Enrollment event. If you are not using a self service application, click on "Logout" to safely exit NIS.

What are the reasons I would need my NIS password reset?

I forgot my password.
My password was disabled after 3 unsuccessful attempts to log in.
My password expired.
The password I was given doesn't work.

What do I do if I lock myself out of NIS?

Have your user ID handy.
Contact the IMServices Help Desk at ***402–471–4636*** *or* ***ihelp@notes.state.ne.us*** *to report the problem.*
The new password will be sent to your agency's Authorized Agent.
They will pass it on to you ASAP.

What if I don't have access to the menus and/or screens I need to do Open Enrollment?

Have your user ID handy.
Contact the IMServices Help Desk at ***402–471–4636*** *or* ***ihelp@notes.state.ne.us*** *to report the problem–tell them what you need and that you don't have access to it.*
Someone will call you to either help you with the fix OR tell you what has been done to resolve the issue

What if I don't have access to a printer (to print my Current Elections, Pay Stub, or Final Benefits Confirmation Statement, etc.)?

This is an agency IT issue–contact your HR or IT representative, not the help desk.

What happens if NIS is not working or is unavailable?

We know that system maintenance will be done on Saturday nights from 6:00 PM to Sunday 10:00 AM–please do not try to log in during those times.
Otherwise, our continual monitoring systems will know there is a problem and will display a message to you as such. The NIS IT staff will work on resolving the problem ASAP. There is no need to call anyone.

Who do I call if I have problems?

If it relates to your Benefits
Check with your agency Human Resource representative
or *call the insurance providers 800 number (see the back page)*
or *call DAS State Personnel Benefits* **402–471–4443**

If System/Technical (computer-related) the IMServices Help Desk
Call **402–471–4636**
or e-mail:
ihelp@notes.state.ne.us

Open Enrollment Meetings

Beatrice		Beatrice State Development Center, Chapel	
Tuesday, October 12	8:00 AM–11:00 AM		
Tuesday, November 2	8:00 AM–11:00 AM		
Grand Island		Grand Island Veterans Home, Auditorium	
Monday, October 18	8:00 AM–11:00 AM		
Thursday, November 4	1:00 PM–4:00 PM		
Hastings		Hastings Regional Center, Building 8: 3rd Floor	
Monday, October 18	1:00 PM–4:00 PM		
Thursday, November 4	8:00 AM–11:00 AM		
Lincoln			
Wednesday, October 20	8:00 AM–11:00 AM & 1:00 PM–4:00 PM	State Office Building, Lower Level Room F–Speakers / Lower Level Room D–Vendor set up	
Monday, October 25	8:00 AM–11:00 AM & 1:00 PM–4:00 PM	Department of Roads, Auditorium	
Tuesday, October 26	1:00 PM–4:00 PM	Gold's Building: Conference Rooms 2C and 2D.	
Thursday, October 28	8:00 AM–11:00 AM & 1:00 PM–4:00 PM	State Capitol, Rooms 1113 and 1525	
Tuesday, November 2	1:00 PM–4:00 PM	State Penitentiary, Visitors Area	***Corrections Employees Only Identification Badge Required***
Tuesday, November 9	8:00 AM–11:00 AM & 1:00 PM–4:00 PM	State Office Building, Lower Level Room F–Speakers / Lower Level Room D–Vendor set up	*Interpreters will be available*
Norfolk		Veterans Home (600 East Benjamin), Auditorium	
Thursday, October 21	8:00 AM–11:00 AM		
Monday, November 8	8:00 AM–11:00 AM		
North Platte		Craft State Office Building, Room 045	
Friday, October 15		8:00 AM–11:00 AM	
Omaha			
Wednesday, October 27	8:00 AM–11:00 AM *	State Office Building Room 127 for speakers, Room 129 for Vendor Set up	*Interpreters will be available*
Monday, November 1	1:00 PM–4:00 PM	Omaha Correctional Center, Visitors Area	***Corrections Employees Only Identification Badge Required***
Wednesday, November 10	8:00 AM–11:00 AM	State Office Building Room 127 for speakers, Room 129 for Vendor Set up	
Scottsbluff		Panhandle Learning Center, Blue Stem Room	
Thursday, October 14	8:00 AM–11:00 AM		
Tecumseh		State Correctional Institution, Visitors Area	***Corrections Employees Only Identification Badge Required***
Tuesday, October 19	1:00 PM–4:00 PM		

Vendor Meeting Agenda

The AM sessions will be

8:00–8:15 Introductions
8:15–8:30 Ameritas / Dental & Vision
8:30–9:00 BCBS
9:00–9:30 Mutual of Omaha

The PM sessions will be

1:00–1:15 Introductions
1:15–1:30 Ameritas / Dental & Vision
1:30–2:00 BCBS
2:00–2:30 Mutual of Omaha

Vendor Customer Service

Ameritas
1–800–487–5553
www.ameritasgroup.com

ASI
1–800–659–3035
www.asiflex.com

BCBS Blue*Choice* / Blue*Select*
1–800–843–2373
www.bcbsne.com

EAP
1–800–666–8606
www.bestcareeap.com

Fortis (Long Term Disability)
1–800–998–7858 ext.. 6082

Mutual of Omaha (Health)
1–800–224–0350
www.mutualofomaha.com

Mutual of Omaha (Life)
1–800–775–8805 (claims only)

TRICARE Supplemental
1–866–919–6571
www.neemployee43.absmil.net

Vision Service Plan
1–800–877–7195
www.vsp.com

Walgreens Health Initiatives
1–800–207–2568
www.mywhi.com

Special Notes

- There are no restrictions on medical coverage during open enrollment. All new enrollees in any medical plan who have been eligible for coverage previously may be enrolled without any health questions or pre-existing limitations.
- More information is available through your agency Human Resource Office.
- Specific questions about coverage can be answered by calling the insurance company's customer service number directly.
- Information regarding health and life benefits can be accessed via the Internet at **www.das.state.ne.us/personnel/benefits**
- If you are a new enrollee into the dental plan, you will be limited to Preventive Services for the first 12 months.
- If you elect to increase your supplemental life insurance option during open enrollment by more than one increment, you will have to provide evidence of insurability and go through the underwriting process. Once the election is made, DAS State Personnel Benefits, will send you the necessary form to complete and return, and notify you of the approval / denial.

ADA–Accommodations

The State of Nebraska is committed to complying with the Americans with Disabilities Act (ADA). Reasonable accommodations, including equal access to communications, will be provided upon request. Please call 402–471–4443.

This Benefits Booklet was published by the staff of the

Statehouse Observer
State of Nebraska
DAS State Personnel
P.O. Box 94905
Lincoln, Nebraska 68509–4905

Editor Keri Bunstock
Director Mike McCrory

Employee Benefits Open Enrollment Worksheet

Be sure you have your log in ID and password before you begin the on-line Open Enrollment process.

Your Name: NIS Employee Number: Social Security # (Tax ID):

Dependent and Beneficiary Information: (The NIS system will assign a new address book number to non-employees.)

Dependent 1

Name (First, MI, Last) Relationship: Gender M F Date of Birth

Social Security #

Phone # Employed Y N Legally Disabled? Y N

e-mail High School Graduate Y N Date of Disability

Street Address Full Time Student Y N Date of Medicare

City, State, Postal Code School Attending:

Dependent 2

Name (First, MI, Last) Relationship: Gender M F Date of Birth

Social Security #

Phone # Employed Y N Legally Disabled? Y N

e-mail High School Graduate Y N Date of Disability

Street Address Full Time Student Y N Date of Medicare

City, State, Postal Code School Attending:

Dependent 3

Name (First, MI, Last) Relationship: Gender M F Date of Birth

Social Security #

Phone # Employed Y N Legally Disabled? Y N

e-mail High School Graduate Y N Date of Disability

Street Address Full Time Student Y N Date of Medicare

City, State, Postal Code School Attending:

Dependent 4

Name (First, MI, Last) Relationship: Gender M F Date of Birth

Social Security #

Phone # Employed Y N Legally Disabled? Y N

e-mail High School Graduate Y N Date of Disability

Street Address Full Time Student Y N Date of Medicare

City, State, Postal Code School Attending:

		Single (Employee Only)	*2 Party (Employee & Spouse)*	*4 Party (Employee & Child(ren)*	*Family (Employee, Spouse & Child(ren)*	*Single (Employee Only)*	*(Employee & 1 Dependent)*	*(Employee & 2 Dependent*
MEDICAL:	Nebraska Blue*Select*	❑	❑	❑	❑			
	Nebraska Blue*Choice*	❑	❑	❑	❑			
	Mutual of Omaha PPO Plan	❑	❑	❑	❑			
	Mutual of Omaha HMO Plan **	❑	❑	❑	❑			
	Mutual of Omaha POS Plan **	❑	❑	❑	❑			
	Preferred Provider Network Only Plan	❑	❑	❑	❑			
	Mutually Preferred POS Plan	❑	❑	❑	❑			
	TRICARE					❑	❑	❑
DENTAL:	Ameritas	❑	❑	❑	❑			
VISION:	Vision Service Plan	❑	❑	❑	❑			

LIFE INSURANCE: Mutual of Omaha

Basic Life ❑

Supplemental Life: ❑ Flat 5,000 ❑ 1 x Annual Salary ❑ 2 x Annual Salary ❑ 3 x Annual Salary

Optional Dependent Life: ❑ Low Option ❑ High Option

LONG TERM DISABILITY:

Fortis (see page 25) ❑ Option 1 ❑ Option 2 ❑ Option 3 ❑ Option 4

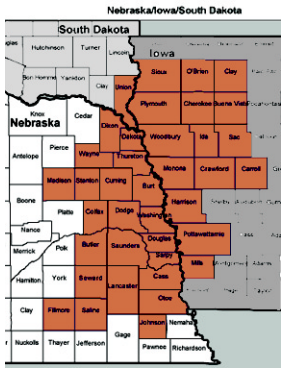
FLEXIBLE SPENDING ACCOUNTS:

ASI (see pages 6 & 7)

Amount Per Pay Period:

Medical Care Reimbursement $_____

Dependent Care Reimbursement $_____



** If you live in the following counties you will need to select a PCP. To determine the PCP in your area you can obtain a directory on line at www.mutualofomaha.com and select the HMO/POS directories.

Nebraska: Burt, Butler, Cass, Colfax, Cuming, Dakota, Dixon, Dodge, Douglas, Fillmore, Johnson, Lancaster, Madison, Otoe, Saline, Sarpy, Saunders, Seward, Stanton, Thurston, Washington, and Wayne.

Iowa: Buena Vista, Carroll, Cherokee, Clay, Crawford, Harrison, Ida, Mills, Monona, O'Brien, Plymouth, Pottawattamie, Sac, Sioux, and Woodbury.

If you do not live in the above counties you do not need to select a PCP.